IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 18, 2002

Re: IRO Case # M2-02-0709

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment is medically necessary. Therefore, ___ disagrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History

This case involves a now 49-year-old female who was injured on ___ when she developed back pain while moving a person in her care. The patient was treated with medication, physical therapy, and epidural steroid injections without significant benefit. An MRI of the lumbar spine on 10/2/01 showed probable left sided L4-5 disc rupture. An EMG 12/4/01 showed left L4-5 nerve root difficulties, probably secondary to the L4-5 disc rupture. Discography on 1/17/02 showed concordant pain at the L4-5 level only, with L3-4 and L5-S1 levels being normal.

Requested Service

Selective Endoscopic Discectomy with Annuloplasty

Decision
I disagree with the carrier's decision to deny the requested surgery.

Rationale
Everything points to the next logical procedure being discectomy at the L4-5 level on the left side, which should accomplish decompression of the L5 nerve root. The procedure in minimumly invasive with less risk of morbidity or post operative scarring than other surgery. Annuloplasty should be determined at the time of surgery, based on the surgeon's confidence in the discectomy alone in dealing with the problem. If a discogenic problem is throught present at that time, then annuloplasty is also indicated.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to:
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,

_____